> "Lila is 27 years old. She is pregnant for the fifth time. Her first child was a boy who is now seven. The next baby, born 20 months later, was very small and died soon after birth. Then came a girl who is now nearly four. She was also small at birth, but survived. Lila's youngest is a boy of 21 months. He is underweight and often sick. She breast-fed all her babies. / Lila works hard for a small wage on a farm 5 km from her home. She finds the work very tiring, especially when she is pregnant. When she gets back to her house, she is too tired to do anything except cook the family's meal. Lila is very thin – much thinner than when she married. Then she weighted 60 kg. After the birth of the last baby, she weighted only 45 kg. Lila has tea for breakfast. At midday she may eat a leftover snack, but there is often nothing to eat. ... Lila has eaten less for the past few months because she is afraid of having a difficult delivery."[1]

Though we in the U.S. are brought up to understand birth as a time of joy and love, and we regard pregnancy with a near sanctity in many cases, others around the world are not so lucky. Quite fortunate to be in what is considered a developed country, Americans often complain about expensive health care, arrogant doctors and the bureaucracy some hospitals contain. No matter how much complaining goes on, one thing is for certain; the majority of American women will give birth to healthy babies in clean and capable facilities and will live well beyond the first two months of their child's life. Yet, maternal mortality for many other countries in the world is a serious and common fact of life. Pregnant women of less developed countries, as they are called, do not have the same privileges of accessible health clinics, let alone suitable facilities, or even skilled birth attendants present to guide them through the birth of their first, maybe only, child.

What is fortunate for women in these countries is that an alarming global

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[1] This story, and many other vignettes like it represent the very basic issues South African women must face in the struggle to fulfill what many see as their biological and societal responsibility; giving birth; Klugman, 22-23.

awareness has been brought on in the last few decades. Much of the world sees problems that they themselves have overcome and seek to help others do so as well. In certain circumstances, additional change comes significantly from the people within the country itself. South Africa can almost be seen as multiple countries in one. For a country that can claim international jazz festivals, modeling showcases with top designers, and Dave Matthews, the lifetime risk of maternal death, 1:110 for every 100,000 live births, is astounding. Compare this to the U.S. at 1:4800 per 100,000 live births[2] and the true hypocrisy and inequality in South African life blatantly shines through. There are many reasons for this inequality, but this paper primarily focuses on the cultural differences between urban and rural women that lead to their incredibly different outcomes for their lives. Health communication programs are constantly being run across the globe to help improve maternal mortality internationally, and the work being done in South Africa follows suit. However, communication is naturally contextual and without an understanding of the cultural contexts in urban and rural areas, health workers might as well be speaking a different language.

When effective health communications programs are implemented, correct, factual health information can be spread, and people will be able to help themselves out a lot more with this knowledge, even if the infrastructure of a perfect health care system has yet to be installed. This paper seeks to analyze health communications in urban and rural areas from a cultural standpoint, acknowledging the important role culture plays in communication. Some of the major communications issues to be discussed on the study of South Africa are the discrepancy between effective health communications in rural and urban areas, the background of racial inequality that led to such stratification and the task

[2] "Table 8: Women"

of communicating with men about ways in which they can affect women's health.

Maternal Health

Pregnancy holds the most risk for any woman's preservation of good health. About 530,000 deaths per year occur during pregnancy, childbirth, or within 42 days of delivery. This number can be broken down as 11-17% occurring during childbirth and 50-71% occurring postpartum, after the baby is born. In addition 13% of these 530,000 deaths are thought to result from unsafe abortions.[3] Unsafe abortions are probably the best understood of all causes of maternal death, but there are many maternal health issues related to pregnancy and childbirth.

The act of childbirth is also considered especially risky because of "the 'three delays:' a delay in identifying complications and seeking care, a delay in transporting the woman to a hospital, and a delay in providing appropriate emergency obstetric care in the hospital."[4] These delays are obviously more of a problem in some areas over others, and also vary depending on socioeconomic status of the woman. If the mother's general health is not good, she runs a greater risk of complications to her pregnancy. Hemorrhage can be related to pregnancy during which a woman may significantly lose blood before (antepartum/prenatal), during or after (postpartum) childbirth. Additionally if a woman who is pregnant has gestational hypertension and develops preteinuria, she may suffer from pre-eclampsia. Eclampsia itself is a late-pregnancy condition during which high blood pressure can cause seizures and is life-threatening. An obstetric fistula occurs when an injury to the birth canal permits bladder or rectum leakage into the vagina. Fistulas can

[3] Skolnik 152 – see also Figure 9-1 from page 153

[4] Skolnik 161

result in social isolation or pariah status. Uterine prolapse is also a health problem related to pregnancy and childbirth in which the woman's uterus may protrude into or out of her vagina.[5] The WHO in an online Q&A session explained the breakdown of how these complications affect maternal deaths.

> Five direct complications account for more than 70% of maternal deaths: haemorrhage (25%), infection (15%), unsafe abortion (13%), eclampsia (very high blood pressure leading to seizures – 12%), and obstructed labour (8%). While these are the main causes of maternal death, unavailable, inaccessible, unaffordable, or poor quality care is fundamentally responsible. They are detrimental to social development and wellbeing, as some one million children are left motherless each year. These children are 10 times more likely to die within two years of their mothers' death.[6]

All of these complications can occur in almost any woman and are not communicable diseases. It is for this reason that proper maternal health care can effectively save lives.

Why Value Culture

There are many valuable reasons to place culture in high regard when examining health communication strategies. Richard Skolnik best sums up the relationship between culture and health with four points.

> First, culture is related to health behaviors. People's attitudes toward foods and / what they eat, for example, are closely related to culture. The food that pregnant women eat, birthing practices, and how long women breastfeed are also linked to their cultural backgrounds. ... Second, culture is an important determinant of people's perceptions of illness. ... Third, the extent to which people use health services is also very closely linked with culture. ... Fourth, different cultures have different practices concerning health and medical treatment.[7]

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[5] Skolnik, 149.

[6] "Why Do So Many Women Die"

[7] Skolnik , 97-98.

Most basically, culture, which in its broadest definition is a way of life, affects the way a person thinks and acts, and gives the person a set of norms and values from which he/she develops a worldview. As Skolnik alluded to, certain cultural practices may even restrict pregnant women from eating certain foods that would normally supply her with the appropriate nutrients needed for a health pregnancy.[8] He cites several studies of different areas in the world where cultural traditions and taboos can adversely affect the health of a pregnant woman and her baby. In Malaysia and Brazil, women were told to avoid certain sources of protein. In southern Nigeria, one study showed that women were to traditionally avoid "sweet foods, so the baby would not be weak; eggs, so the baby would not grow up to be a thief; [and] snails, so the baby would not be dull, salivate excessively, or not develop speech properly."[9] However, as Skolnik admits to, culture is not homogeneous. In every society exists what some scholars refer to as subcultures. South Africa is one country in which groups of people must not be generalized about too quickly. Just as ethnic background can attribute to culture, so can gender, socioeconomic class, living environment, race and the intermixing of any of these variables.

Health Communication Models

When dealing with culture, some of the most readily applicable models of health communication are the Health Belief Model, Stages of Change Model, and Social Cognitive Theory. Developed by the U.S. Public Health Service in the 1950s the Health Belief Model is probably the most well known of all health behavioral theories. This theory, meant to explain why people do or do not take certain actions regarding their

[8] Skolnik, 98.

[9] Skolnik, 100.

health developed six determinants of the propensity to act. Theorists say people will act if they: "believe they are susceptible to the condition (*perceived severity*); believe the condition has serious consequences (*perceived severity*); believe taking action would reduce their susceptibility to the condition or its severity (*perceived benefits*); believe costs of taking action (*perceived barriers*) are outweighed by the benefits; are exposed to factors that prompt action (e.g., a television ad or reminder from one's physician to get a mammogram) (*cue to action*); are confident in their ability to successfully perform an action (*self-efficacy*)."[10] With regard to culture, the Health Belief Model's determinants are all in effect products of worldview and cultural norms. Perceived severity can be greater or less depending on the way religion or traditional medicine explains a certain illness, self-efficacy can be determined by cultural gender roles, and so on.

The Stages of Change Model, developed by Prochaska and DiClemente is based on a premise "that behavior change is a process, not an event."[11] The model asserts that each person attempting to change a behavior goes through five stages: precontemplation, contemplation, preparation, action, and maintenance. An outsider can only help the person change his/her behavior if methods are used that are applicable to the person's stage of change. For example, a health worker who delivers boxes of unfamiliar nutritional supplements to the house of a women whose children are underweight should be sure that the woman is in the action stage, ready to feed her babies supplements, and not in the contemplation stage, where she is still considering the relative importance of these strange new foods. Cultures change over time, and because they do so very slowly, it is important for health workers seeking to change a dangerous or unhealthy cultural

[10] Theory at a Glance, 14.

[11] Theory at a Glance 15.

tradition to feel out the group's stage of change. Otherwise, years of research and project planning can be lost with one overzealous move.

Social Cognitive Theory is probably the most obviously linked to culture because it describes the interchanges between people and their environment. It "describes a dynamic, ongoing process in which personal factors, environmental factors, and human behavior exert influence upon each other."[12] The idea is that a person and his/her environment do not produce mutually exclusive changes in behavior. Rather, any change made by the person affects the environment and vice-versa. There are many facets to Social Cognitive Theory as it incorporates concepts from a variety of behavior change models. Even without exploring Social Cognitive Theory in depth, however, culture's place in this theory is in fact the entire theory itself. The assumption that people's actions affect not only their own persons immediately leaves a gap where culture steps in and assumes the role of the environment. Though none of the case studies later analyzed in this paper expressly refer to any of the above models in particular, their methodologies are explained so that they can fit into combinations of these communications models.

The Problems of South Africa

The Millennium Development Goals (MDGs) were determined in 2000 as part of the Millennium Declaration of the United Nations Millennium Summit. All countries party to the signing of the MDGs are expected to achieve these 8 goals with 15 core targets by 2015. Goal 5 is simply: Improve Maternal Health. Specifically, the target with Goal 5 is to "[r]educe by three quarters, between 1990 and 2015, the maternal mortality

[12] Theory at a Glance, 19.

ratio."[13] There are links between women's health and six of the MDGs, however, assuring that improving women's health is essential toward much future progress.

South Africa is an interesting case for the study of women's health. Though some of the world's earliest human settlements have been found within the present-day country's borders, the people of South Africa have a long history of forced diversity.[14] It is precisely this diversity, however, that can be faulted for numerous inefficient health communication practices, and only when cultural diversity is accounted for in communication efforts can any type of success be achieved. The country's past development history and its present demographic makeup present huge roadblocks for the simple success of health communication programs.

Though Bantu-speaking farmers first began settling in the northern part of the country some 1,500 years ago, the Dutch established the first permanent settlement at Table Bay in 1652. The Dutch began bringing African and Asian slaves to the region and the colony almost instantly became stratified as a hierarchy based on race. In 1795, the British took over Dutch possessions and began adding to the mix of cultures South Africa would eventually become known for.[15] Afrikaners are one cultural group in South Africa who, from the 20th century on, were defined as those whites whose native language was Afrikaans[16], a creolized form of Dutch that had developed since the establishment of the

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[13] Skolnik, 10-11.

[14] Though an appropriate understanding of South African history is necessary to realize cultural implications for women's health there today, this paper is not meant to thoroughly detail historical data and will instead only touch upon specific points of reference relevant to culture in rural and urban areas. Unless otherwise indicated, the following historical data comes from, *Historical Dictionary of South Africa*.

[15] Saunders, xli-xliii.

[16] Saunders, 11.

first white settlement in the 17th century.[17] The British were another group who fought many wars in South Africa and maintained strong connections with the country up until the present day. As conflicts between these white settlers and indigenous peoples grew, racial tensions followed suit. In 1948 when the National Party took over, racial and cultural inequalities grew increasingly strong. Orieji Chimere-Dan explains some notable marks in the country's history that would segregate races and cultures even further.

> [T]he Population Registration Act (Act No. 30 of 1950) mandated the classification of the population into racial groups on the basis of skin color. The Immorality Act (No. 23 of 1957) limited freedom of choice of marriage partner and thus affected marriage patterns. The Group Area Act (No. 41 of 1950) effectively determined rural-urban population composition of the races, and the Reservation of Separate Amenities Act (no. 49 of 1953) discouraged racial social mixing, thereby consolidating race-specific demographic behavior.[18]

Clearly, the laws preceding apartheid laid the groundwork for separating geographic areas by culture. The National Party set up apartheid to discriminate based on race in terms of four classes of people; whites, Coloureds, people of mixed descent, Asians, which included Indians and Malays, and Africans, people of Bantu-speaking origin. In particular 1948 saw the definition of 10 bantustans, homelands, to which blacks were assigned based on their home language, and each homeland was set out in a rural area quite a distance from the city.[19] The incredible oppression seen during apartheid was not seriously changed until the ideology's central pillars were abandoned in the early 1990s, and the first democratic government, the African National Congress (ANC) took power.

In this era, South African Health Services "were 'fragmented, vertical, and overlapped between provincial and local government authorities,' though they were still

[17] Saunders 6.

[18] Chimere-Dan, 32.

[19] Kaufman, 106.

of a relatively high standard. The public health system was oriented toward tertiary care (the most sophisticated and expensive, curative procedures), while primary care remained underfunded[20] The 1990s were a difficult time for South African women, both urban and rural to achieve what they needed. The Women's Charter for Effective Equality, adopted at the national convention of the Women's National Coalition in February 1992 said in Article 11, "Health: Equal, affordable, accessible and appropriate health care services, which meet women's specific health needs and which treat women with dignity and respect, shall be provided. Women should be made aware of their rights in relation to health services. Health services must be appropriately orientated to meet women's health needs and priorities. Basic life sustaining services, such as water and sanitation, which ensure good health, must be made accessible to all South Africans by the state."[21] But even though obvious changes were being made from a government standpoint, women in South Africa still felt burdened. At the 1994 Women's Health Conference in Johannesburg, "Tshepo Khumbane, assistant director of the Environmental Development Agency, painted the South African picture:

> 'The load has grown too heavy for the women, both urban and rural. For rural women it is worse because of the collapse of the division of labour through migratory labour...the grassroots woman carries the worst physical and psychological burden...and yet no one appreciates her...She is humiliated. The very man who has evaded his responsibilities, beats or at times kills her...The patriarchal society has lost a sense of judgement and appreciation for what women are worth in this country. We are still sacrificing our health for the comfort of men and our children and yet no one appreciates [this]. Even the law fails to acknowledge [that]...the woman who cleans the dirt must be given the right to step up on her own. That is what the RDP is all about.'"[22]

[20] Knudsen, 15.

[21] Klugman, 43.

[22] Klugman, 5.

South African abortion legislation changed significantly in 1996, but women still face problems accessing abortions today. “Second trimester abortions, an inherently more risky procedure, continue to be 20% of all abortions.”[23] In the case of health related to abortions, it is important for health professionals to understand the reasons behind delayed abortions for both rural and urban women in the present-day country.

Today, official statistics telling of South Africa’s demography and health can be surprising, and they represent even further the problems health workers face.[24] The total population of South Africa was estimated as of July 2008 to be 43, 786,115. [25] As of 2006, 60% of this population was considered urbanized by UNICEF.[26] The urban population in South Africa is growing at a rate of 59% annually. Women in South Africa can anticipate a life expectancy of 52,[27] and they face much worse statistics in terms of specific maternal health conditions. In 2002, 86% of urban South Africans had access to improved sanitation while only 44% of their rural counterparts did as such.[28] The lifetime risk of maternal death in South Africa is 1:110 per 100,000 live births, though the percentage of coverage of antenatal care and the presence of a skilled attendant at birth are both 92%.[29] Other statistics from 1990 state that “rates [of maternal mortality] per 100 000 live births were five for Asians, eight for whites, 22 for coloureds and 258 for

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[23] Harries, et al. - 1

[24] Because the CIA’s World Factbook data was the most recently published, some of the following demographics come from their statistics and those that do not are taken from WHO data.

[25] “The World Factbook – South Africa”

[26] UNICEF South Africa

[27] “Country Health System Fact Sheet”

[28] “Country Health System Fact Sheet”

[29] “Table 8: Women”

African women," and these figures are claimed to be representative of lasting effects from the apartheid era.[30] Comparatively, however, 75.5% of rural births are attended by skilled personel as opposed to 93.4% in urban areas. An article published by Health24 also helps to fill in some missing data. With respect to birthing practices, the article states that 98% or white women and 96% of Indian women delivered in clinics or hospitals while 25% of Africans and 16% of Coloureds had home births. The article also stated that "22% of African women do not have a health professional present at the birth."[31] Other data shows there are 34,829 physicians in the country, which account for a density of 0.77 per 1,000 people.[32] These statistics represent the discrepancy between the lives of rural and urban people, especially women, and unfortunately, some programs targeting at improving women's health do not discern between the two life styles and cultures.

Rural Women

The diversity of South Africa makes it the perfect country in which to explore culture, but also makes it difficult to classify particular areas as monolithic. That being said, the plight of rural women is largely that of black women in low socioeconomic classes. Women who still live in rural areas as their ancestors once did often come to the table of health with a completely different set of cultural traditions than health development workers are used to. One important aspect of rural life is that since precolonial days, Bantu-speaking societies were largely patriarchal in which men

[30] Klugman, 374.

[31] http://www.health24.com/Woman/Medical/711-727,13057.asp

[32] "Country Health System Fact Sheet"

controlled women's reproductive labor as it represented wealth. Women were, however, recognized for their status in their ability to cultivate crops. [33]

Indigenous women also partook in some very interesting traditional practices surrounding pregnancy and birth. In 1890, James Macdonald published an article entitled, "Manners, Customs, Superstitions, and Religions of South African Tribes." From his 12 years in Africa, Macdonald gathered some interesting observations on various tribal customs, especially those involving pregnancy and childbirth. He noted that there were no seriously evil consequences if women chose not to abide by the dietary restrictions set out in pregnancy, however customs after the child's birth were quite different. The mother would be secluded for a month, time kept track of by the passing of the moon, with the father being sure to check up on her. Also traditionally comes the slaughtering of an animal by the father to protect the child during its first years.[34] He continues to describe certain practices the people of these indigenous tribes carried out at the cause of a pregnancy.

> During incubation the wise women sprinkle the child daily with a decoction of herbs, and repeat, certain rhymes, mostly utterly meaningless, which are supposed to ensure natural development and physical health. Then there is a fire of aromatic tomboti wood kindled at intervals on the floor, and the child is passed and repassed through the smoke. This insures mental vigour, wisdom, valour, strategy, and eloquence of speech. The spirit of fire escapes in the smoke as it ascends, and this the child receives and retains, providing the smoking process is duly performed by qualified persons. Children are never killed or maimed at birth, and a large family is regarded as a mark of special honour.[35]

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[33] Saunders, 281.

[34] Macdonald, 266-67.

[35] Macdonald, 267.

Though Macdonald breezed over the significance of food taboos for pregnant women, Barbara Klugman discussed them much more in-depth. She explains that in traditional cultures, Xhosa women were prevented from eating bone marrow, sweets, potatoes, or pumpkins while carrying a child. Zulu women also faced dietary restrictions during pregnancy, as they were unable to consume eggs or milk. Though many would write-off these practices as incomprehensible ancient traditions, Klugman points out that some researchers suggest food restrictions were meant to lessen the scarcity of certain valuable nutritious foods.[36]

Traditional societies not only had dietary practices to follow, but sexual ones as well. Knudsen explains that in addition to more traditional family planning and contraceptive practices, sex during and after pregnancy often faced harsh restrictions.

> As long as a woman continued to breastfeed, her husband would ejaculate outside the vagina to protect the infant from semen, thought to seep into the rest of the woman's body, contaminating her breast milk and harming the baby (hence, the widespread practice of *ukusoma* – "thigh sex"). Most of these traditional societies believed that a woman should not become pregnant again until her child is weaned and able to stand or walk. For hundreds of years, midwives and traditional healers aided women in using local herbs for both contraception and abortion.[37]

In these indigenous societies, family planning was practiced, and great pains were taken to protect the health of mother and baby, but without the knowledge of modern medicine today, and with different material needs, some traditional practices hurt women more than they helped.

Perhaps the most important development in the history of black women's health in South Africa came during the apartheid regime. Knudsen looks at the years around 1974 in particular when women in rural areas were almost always soley given the option of

[36] Klugman, 5.

[37] Knudsen, 12.

long-term injectable contraceptives, such as Depo-Provera as a method of government sanctioned family planning. Near thousands of black women were given the shot immediately after childbirth without their knowledge or consent. “Similarly, some doctors have been charged with performing tubal ligations after a cesarean section without the woman’s knowledge or consent. Testimony before the Truth and Reconciliation Commission in 1998 revealed an extreme example of the apartheid government’s determination to control black fertility: The Chemical and Biological Warfare Program of the South African Defense Force undertook research for an infertility vaccine intended for use among black women.”[38] The apartheid government effectively tainted the idea of family planning with negative memories and life-scarring thoughts. In response to the overwhelming repression many blacks felt under the government’s family planning program, the outcry to increase black fertility became strong. These concerns however did not necessarily coincide with black women’s health issues. “The political call for ‘freedom babies,’ or ‘people’s rejection of population control’ seemed to have more to do with political positioning than with the constraints of women’s lives.”[39]

After apartheid, national health indicators proved the results of discrimination to have devastating effects on blacks in South Africa. “[A]t the time of the government change in 1994, the infant mortality rate for blacks was ten times higher than the rate for whites, and the maternal mortality rate for blacks was sevenfold that for whites.”[40] Additionally, as black women were subjugated to a lower socio-economic status for quite some time, which resulted in their living in poorer urban areas, they often lack the health

[38] Knudsen, 13.

[39] Kaufman, 109.

[40] Knudsen, 14.

care for which they are in the most dire need. Logistically, rural areas have less reliable transportation systems, which are necessary for healthy child-birthing practices, if women must quickly get to a medical facility. “Transport is lacking in rural and squatter settlement areas, as are opportunities for education on health and related issues.”[41] If any of these issues were to be fixed, strategies for effectively communicating health information in a cultural context would be necessary.

Urban Women

Just as was stated above with the descriptions of rural society, the culture of urban women cannot be entirely summed up in one description. For the purposes of this paper however, urban women refers to those usually white women of higher socioeconomic status than their rural counterparts, though in some instances, city slums may be mentioned. As far as early settlers go in South Africa, society in the 18th and 19th centuries for Boer and British women brought on patriarchy quite similar to that of indigenous societies, with the exception that these white women were not as often recognized for their work.”[42] At the beginning of the 20th century, when white supremacy grew as an ideology white women were told that abortion was a threat to their racial superiority. “The South African judicial system concurred, and abortion became a ‘crime against the state.’”[43] The Abortion and Sterilization Act was passed in 1975 by the “99 percent male, all-white South African Parliament...." [44]

[41] Klugman, 374.

[42] Saunders, 281

[43] Knudsen, 12.

[44] Knudsen, 13.

> [The Act stated that a] woman was eligible for a legal termination of pregnancy only if she met one of the following criteria: the pregnancy seriously threatened her physical health or life; continuing the pregnancy would result in permanent damage to her mental health (usually defined as brain damage only); the fetus could be proven 'irreparably' seriously handicapped (for example, if it had no brain); the woman was legally classified as an 'imbecile'; or the woman could prove the pregnancy was a result of rape or incest. Two doctors had to swear that the woman met one of these conditions before she would be granted a termination.[45]

The family planning program of 1974 also sought to help achieve the government's end goal of white supremacy. Patients seeking health care during this time were forced to pay fees for nearly all health services with the exceptions of contraceptives, sterilization, and exams for rape and assault victims.[46]

Current Status of Women's Health Care in South Africa

In South Africa, two forms of medicine, traditional and Western are said to exist. Traditional healers developed out of old indigenous practices from many different cultural groups. The ANC put forth a policy about traditional healers with the expressed intent to integrate them into society. The policy outlines a number of principles including one specifically related to broader health communications. Because traditional practitioners can often be more accessible than other more orthodox medical practitioners, there is a push to recognize and take advantage of this situation to promote better health.[47] But beyond this simplistic understanding of how the medical systems in South Africa are set up, governmental policies regarding maternal health, and abortion in

[45] Knudsen, 13.

[46] Knudsen, 13.

[47] Klugman, 457.

particular may provide more insight into the health development than any other information.

For many reasons, especially the government's stance on legalizing abortion, South Africa is considered one of the most liberally-minded African countries in terms of health policy. The year 1996 saw the ANC legalize abortion "in one of the most sweeping abortion reforms in the world."[48] The passage of this law gave incredible new rights to South African women. "South Africa and Zambia [are] the only countries in sub-Saharan Africa that permit abortion for social reasons."[49] Part of this success was due to the new Patient Charter, protecting women from any type of forced contraception or sterilization. In addition, the Sterilization Act of 1998 lists conditions under which women have the right to a sterilization.[50] In 1994, the South African minister of health, Dr. Nkoszana Zuma, gave pregnant women and children five years of age or younger the right to free health care. The ANC spent $3.62 billion on health care in 1996-1997, which accounted for 10% of its total budget.[51] However, free health care is not enough. If women do not know they can receive free health care, or if they simply cannot reach medical facilities easily, health care price is no longer a determinant of maternal health.

A new Health Act was established in 2005. "This provides for the mandatory establishment of DHCs [district health council], with formal representation from local government politicians who are democratically elected. Some Health Systems Trust (HST) experiences in some districts in the Eastern Cape province confirmed that they are still in the early stages of dealing with the very initial steps, dealing with the legal aspects

[48] Knudsen, 14.

[49] Harrison, et al., 425.

[50] Knudsen, 15.

[51] Knudsen 15

of defining the scope of their authority and the separation of power between local authorities and provincial departments, which are separate spheres of government, not different levels. "[52] Again, due to the fragmented nature of South Africa's post-apartheid health care system, lines still need to be drawn more clearly concerning health care system responsibilities and communications must be handled more efficiently.

As far as rural health care is concerned, huge problems still exist with access to suitable care in these areas. An unequal distribution of medical workers plagues South Africa. "Many health workers, especially doctors and pharmacists, live and work in the major urban areas. Meanwhile, there is a severe shortage of staff and supplies in rural areas and informal settlements. Many rural workers have to rely on mobile clinics which only come once every six weeks and offer a limited range of services only. Some rural hospitals do not even have a full-time doctor."[53]

Case Studies

To further analyze the specific issues surrounding pregnancy and birth in South Africa, the following are two case studies detailing specific South African females' account of how the system is or is not working for them. Abigal Harrison, et al., completed a study in 2000 analyzing South Africa's Termination of Pregnancy Act, "the most liberal abortion law in Africa, [which] took effect early in 1997. In spite of the anticipated benefits to women's health, however, public reaction has been mixed. In the country's most populous province, KwaZulu/Natal, opposition is strong and most health

[52] Baez and Barron, 26.

[53] Klugman, 475.

care providers have refused to provide the service."[54] Though a two surveys and in-depth interviews, Harrison's team sought to understand attitudes and beliefs about reproductive health issues, including abortion, and knowledge of the law itself. The results clearly showed that passage of the act was not enough to ensure safe abortions were accessible to all women. "Support for the Act was low (11%) among both community members and nurses, and few supported abortion on request (18 and 6% respectively). Within each group, however, a clear hierarchy of support was observed: a majority of nurses (56%) and community members (58%) supported abortion in the case of rape or incest, or if the continued pregnancy would endanger a woman's health (61 and 56%, respectively), but few supported abortion for social or economic reasons"[55] In this case, communication was not effectively used initially to explain the proper connotations of the law, and the community formed opinions which may have been aggravated due to their ignorance.

Harrison, et al., created an effective research strategy for the potential implementation of a future health program with the rural population. Though surveys are a most basic form of collecting research, her use of in-depth interviews truly allowed her to discover legitimate information about the mindsets of the people within the community and the nurses with whom she talked. With her background research, she would probably be able to construct a program based on the Health Belief Model, seeing as she now has a better understanding of how women perceive the law and how much of its fact they actually comprehend. The Health Belief Model can be used here to effectively target the myths or lack of knowledge women use when forming opinions about the law, and permitting for those opinions to change.

[54] Harrison et al., 424.

[55] Harrison, et al., 424.

A second case study came out of KwaZulu/Natal in 2003. Christine A. Varga, sought to present a study on gender roles in Zulu adolescent reproductive health and pregnancy. Her work highlighted cultural differences in regard to pregnancy from rural and urban viewpoints, but also from those of young men and young women. Her methodology was very clear and fit the practice of working within a Health Belief Model. She first collected background data relevant to the social situation of adolescent pregnancy in focus groups. "The discussions served as an initial step in defining the social parameters of adolescent sexual activity, contraceptive use, and pregnancy; by assessing sensitivity about these issues; and by gaining a better understanding of potentially relevant linguistic subcultural differences between rural and township adolescents."[56] After that the study explored factors serving as a base for unprotected sex and young female contraception, how to deal with the pregnancy, social repercussions faced by a young pregnant girl, and the effects on her life the first year after her child is born.[57] Varga then implemented one-day narrative workshops which incorporated role playing and discussion, each moderated by a field-worker of each sex, and each session was tape recorded.[58] After the workshops came in-depth interviews. Her results clearly pointed to cultural factors contributing to adolescent pregnancy and the stigma surrounding it.

> Of great importance to young people's gender ideals and roles are their beliefs concerning appropriate social conduct. Regardless of sex, participants' behavior is governed by the concept of respect or dignity (*ukuhlonipha* in Zulu, meaning respect or behave properly)."[59] "During a focus-group discussion an urban boy described this dynamic in the

[56] Varga, 162.

[57] Varga, 162.

[58] Varga, 162.

[59] Varga,163.

> following manner: When [women] say ‘no’ they mean ‘yes.’ [A woman] can never come out clearly and say ‘Let’s do it.’ You need to read her facial expre / ssion....If she keeps on saying ‘no’ and closes her eyes, she wants it [sex].[60]

Varga further explained this concept of respect when a 24-year-old urban girl explained that strategies were knowingly employed, because they were socially acceptable, which often lead to violent sexual encounters. “When we say ‘no’ we mean something else,” said the girl. “Women often test a man just to see what he is going to [do]. Not that we do not want to have sex. But we have to show that we have dignity [ukuhlonipha]. We are also curious to find out what men are capable of. In the end, men lose patience and react violently.”[61]

Varga’s study also found that based on personal experience, 67% of urban women and 35% or rural girls claimed to have secretly been using contraceptives.”[62] This difference in percentage may mean that rural girls do not use contraceptives or that they simply never feel comfortable admitting it, no matter how anonymous or open they feel. Either way, clear evidence exists that differences between urban and rural women lead to different perceptions and practices involving contraceptives.

Motherhood was seen as important in the lives of most of the young South African women in Varga’s study, but its importance did not trump the setbacks felt by these same women once they became pregnant. Particularly rural girls were shown to stress the conflict between the nature of their traditional fertility values and various other modern day factors attributing to successful and stable lives. “A girl describes changes in her social status after she became a mother ...: [I could feel] there was a big difference

[60] Varga, 163-164.

[61] Varga 164.

[62] Varga 164

between us, because [I am] left behind people my age.... I had my child [but she] with no child, felt she was better because she has none.... [O]thers would say we are the same.... If you look at my legs and [hers], you can see no difference. But it hurts because she thinks she is better."[63]

Part of Varga's conclusions included that childbearing as a form of attaining respectability is much stronger for rural youth than urban youth. "Nonetheless, even among rural young people, early parenthood is looked upon as increasingly socially 'expensive' ...."[64] Varga's most significant, overarching conclusion is that future health programming must be implemented with regard to gender, another subculture like socioeconomic class, that requires attention. Her prescription for future health development workers in South Africa includes points about areas where communication is needed most. "Regarding pregnancy prevention, emphasis [in future programming] should be placed on behaviors such as frequent and unprotected intercourse, violent sexual encounters, and poor communication between partners. Another important point of programmatic focus is increased male involvement in sexual and reproductive health matters."[65]

Much of Varga's work involved the understanding of Social Cognitive Theory. Every behavior she uncovered in her research and her overall finding of the importance of respectability reinforce the presence of strong connections between the adolescents and their communities when seeking a change in behavior. Cultural norms, peer pressure, gender stereotyping, and even interactions with parents were at the source of many

[63] Varga 166

[64] Varga 169

[65] Varga 169

actions the adolescents in her study chose to take. Recognizing the importance of social structures in this case would be essential to inspiring any type of change in perceptions of adolescent pregnancy, the ways young women choose to handle their pregnancies, and the overall mental and physical health of young women in these difficult positions.

Non-governmental work (Planned Parenthood Association of SA)

One non-governmental group trying to implement new policies and procedures for health communication in South Africa is the Planned Parenthood Association of South Africa (PPASA). Though the PPASA's website has not been updated since October 2004, the organization provides a full list of programs they have been working on to change the health problems in South Africa. Standing out in their plan for future effective health communication is a program that targets men. A common theme in less developed countries today is that while women's education and women's empowerment are making great strides, programs have left men behind. As a crucial part of women's health in particular, the PPASA seeks to empower men as well. The statement on their website clearly identifies the reasons the PPASA sees for its approach:

> For many years, campaigns around sexual and reproductive health, HIV/AIDS and gender violence focused their attention on empowering women. As important as this work is, very often the people who need the information just as much if not more than women - the men - were left out. Men As Partners (MAP) is a PPASA programme that aims to change that by bringing men on board through specially designed education and training programmes looking at a variety of focus areas within sexual and reproductive health. [66]

[66]PPASA – Programmes; All future data about the MAP program comes from this website.

The MAP program began in 1998 and seeks to reach out to both men and women on gender equality, and several health issues (reproductive, HIV/AIDS, domestic violence, etc.) involving relationships between the sexes. To create awareness and inspire changes in attitudes and behavior, the program conducts life skills workshops, offers professional training and produces educational materials. The program's goals are to: "improve men's awareness and support of their partners' reproductive health choices; increase awareness and responsibility for prevention of STIs and HIV/AIDS; increase understanding of the benefits of gender equity and healthy relationships; increase awareness of and strive to prevent domestic and sexual violence; and improve men's access to reproductive health information and services." [67] The program considers itself fully adaptable, able to work in community or professional settings, and urban and rural areas.[68]

Need for cultural awareness in health communication

One initiative that the South Africa is putting forth in hopes of fostering better initiatives for women's health is the research completed by the Community Responsiveness Programme (CRP), in Tzaneen, Mopani District. Though this program addresses violence against women, children and men, the fact that it is community based research which focuses on perceptions makes it a great example of communication being the focus of change. "In a country like South Africa, this serious public health problem needs a collective response that emanates from the community itself such as in this case." [69] Additionally, because district health officials and clinic committee members took part

[67] PPASA - Programmes

[68] PPASA - Programmes

[69] Baez and Barron, 15.

in the research and have rights to the results, they may be more willing to support community based research in the future, providing even more doors for health workers to come in and develop communication programs."

A development in South African health care in 1994 is still showing a few of its successes today. The government in 1994 set forth the Primary Health Care (PHC) approach. Again, because community participation was encouraged in this program its connection to the people is significantly stronger and thereby has the tools to be more effective. "In the Monyakeng Location, in the Free State province, the clinic committee ... meets regularly and has a number of very keen members: sometimes even the ward councillor attends meetings. Although they are a dynamic group of people, they feel ignored by the authorities."[70] The group primarily works on their own but has seen improvements in their TB indicators and success with outreach programs for HIV and STIs. If more community health programs are established, it is argued that the formal health system will be strengthened as a result. Baez and Barron, who wrote about this case in particular feel that if this health communication does not progress past the community level, then this case in South Africa may resemble a similar situation in Zimbabwe where the chance for change is severely losing steam.[71]

Conclusions

South Africa can be seen as a country with many contradictions. There are extreme highs and lows of socio-economic class, and gross discrepancies between the health care women receive are two prime examples. Though great strides have been made

[70] Baez and Barron, 11.

[71] Baez and Barron, 11.

since apartheid to equalize the health care between men and women and between urban and rural women, some problems are simply not getting fixed. At a conference held in Cape Town on April 16 of this year, health experts from around the world concluded that not enough progress is being made to reduce mortality worldwide of children and mothers. Discussion was held over what new action could feasibly accelerate the move toward achieving MDGs 4, on reducing child mortality, and 5, maternal mortality.[72]

Perhaps what the discussants are missing is a closer attention to culture. As seen in the above research, the differences between urban and rural areas of South Africa are acknowledged, yet no comprehensive health communication programs have been implemented at the aim of treating South Africa as one country with multiple subcultures. If this type of program were successfully carried out, the country could maintain its unique cultural diversity, take advantage of culturally tailored health communication programs, and still remain as one unified nation. Discovering the means to this end is beyond the scope of this research, but a bit of optimism never hurt in brain-storming.

South Africa will need to carry out policies with respect to cultural identities of its citizens, especially in the near future. As globalization continues to be an oft discussed phenomenon, so too will the struggle to proclaim unique cultural identities so as not to be lost in the whirlwind of information and theoretical homogenization globalization can bring. To further the purpose of this research, more in depth field study must be done to examine what local South African NGOs are doing to improve maternal health in both urban and rural areas. Additionally, several focus groups and research in South African communities must occur to definitely determine how urban and rural women define their

[72] *UNICEF Press Release*

cultures differently. More respect to culture will produce more effective communication and hopefully improve maternal health in South Africa and the world as well.

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